Nature and Extent of Poverty

Queensland Aboriginal and Islander Health Council submission

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SUBMISSION

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QAIHC
Queensland Aboriginal and Islander Health Council

Chief Executive Officer
Queensland Aboriginal
and Islander Health Council
PO Box 3205
South Brisbane, Qld 4101
P: (07) 3328 8500

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QAIHC
Queensland Aboriginal and Islander Health Council

QAIHC SUBMISSION TO THE SENATE STANDING COMMITTEES ON COMMUNITY AFFAIRS

About the Queensland Aboriginal and Islander Health Council (QAIHC)

QAIHC is the peak body representing the Aboriginal and Torres Strait Islander Community Controlled Health Organisations in Queensland at both a state and national level.

QAIHC represents 33 ATSICCHOs and 11 associate members who share a passion and commitment to addressing the unique health care needs of their communities through specialised, comprehensive and culturally appropriate primary health care. QAIHC as the peak of ATSICCHOs of Queensland, wish to express the collective views on behalf of our state-wide members, regarding the Commonwealth Government's 2023-24 budget.

1. Opening statement

QAIHC acknowledges the extent of poverty on Aboriginal and Torres Strait Islander peoples and communities across Queensland. Poverty in relation to Aboriginal and Torres Strait Islander peoples is often connected to intergenerational impact due to colonisation, past and present policies, institutional racism, and lack of hearing the voice of Aboriginal and Torres Strait Islander people.

Despite efforts towards Closing the Gap in several social-economic areas, between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians, Aboriginal and Torres Strait Islander peoples remain one of the most disadvantaged and marginalised people. Poverty in Aboriginal and Torres Strait Islander households is multi-faceted but is largely a result of the impacts of colonisation and previous and current government policy. Poverty significantly impacts all aspect of health.

Poverty within Aboriginal and Torres Strait Islander people and communities needs to be understood as both a cause and an effect of social disadvantage, intergenerational trauma, and institutional racism. QAIHC highlights that urgent policy action is required to ameliorate the growing prevalence of poverty and its effect on health among Indigenous people.

This submission addresses the role that both Governments and the ATSICCHO sector can play to address, manage, and prevent health issues that is a result of poverty amongst Aboriginal and Torres Strait Islander communities across Australia, and further support The National Agreement of Closing the Gap[1]

2. Recommendations

Recommendation 1: That more comprehensive measures are developed to understand the true extent and nature of poverty for Aboriginal and Torres Strait Islander individuals, families and communities.

Recommendation 2: To assist in breaking the cycle of intergenerational poverty that Government agencies invest in financial counselling services designed by, and for, Aboriginal and Torres Strait Islander people that can be delivered in partnership with Aboriginal and Torres Strait Islander Community Controlled Organisations.

Recommendation 3: As poverty impacts upon choice and access to services it is therefore essential that Commonwealth and State Government agencies undertake clear action to identify, acknowledge and address colonisation and the ongoing intergenerational trauma to increase accessibility and trust across sectors and public service delivery. In particular, taking the following actions:

- To progress toward priority reform three of the National Agreement on Closing the Gap, all Governments must priorities the acknowledgement of Aboriginal and Torres Strait Islander people's history through truth-telling.
- To progress toward priority reform three of the National Agreement on Closing the Gap, all Governments must embed high-quality, meaningful approaches to promote cultural safety, recognising Aboriginal and Torres Strait Islander strengths.
- Prioritise and deliver services in partnership with Aboriginal and Torres Strait Islander community-controlled organisations, communities and people.
- Continue investments to improve access to safe housing for Aboriginal and Torres Strait Islander peoples in Queensland to align with priority reform one and two of the National Agreement of Closing the Gap.

Recommendation 4: That the Commonwealth and State Government agencies to align with the priority area two in the National Agreement increase capital works and funding for service delivery to ATSICCHOs to ensure culturally safe provision of comprehensive primary health care and health promotion program addressing the impact of colonisation and previous Government policies.

Recommendation 5: That the Commonwealth and State Governments invest in co-designed and co-owned health prevention strategies that consider the economic and cultural aspects of the Aboriginal and Torres Strait Islander communities they are delivered within. These recommendations must consider the rising cost of living experienced in Queensland.

3. The true rate of poverty in Aboriginal and Torres Strait Islander populations

Response to: (a) the rate and drivers of poverty in Australia,

On all standard indicators of poverty and disadvantage, Aboriginal and Torres Strait Islander peoples continue to be the most deprived population group across Australia. It is estimated that approximately 1 in 3 Aboriginal and Torres Strait Islander households have income poverty significantly affecting their ability to purchase healthy foods, afford safe housing, access to health care, education and employment [2]. The prevalence of Aboriginal and Torres Strait Islander peoples living in poverty is significantly higher in remote and very remote areas of Australia. Today is it estimated that 54% of Aboriginal and Torres Strait Islander peoples living in remote and very remote areas live in poverty [3]. The number of Aboriginal and Torres Strait Islander peoples living in poverty in Queensland is expected to be similar to national data.

In Australia poverty is defined as a state of having few material possessions or little income which the acknowledgement of that poverty can have diverse social, economic and political causes and effect. In this submission the form of poverty that is defined as limited material possession will be termed "material poverty". Material poverty is measured through household disposable income. Families are

considered poor when their household income falls below a level considered adequate to achieve an acceptable standard of living[4].

It must be noted that accurate measurement of material poverty in Aboriginal and Torres Strait Islander communities is hampered by the complexity of family structures and income sharing arrangements, all of which likely results in under-estimation of poverty in Aboriginal and Torres Strait Islander communities[5].

Poverty is a large issue within the Queensland Aboriginal and Torres Strait Islander populations with devastating consequences, however for Aboriginal and Torres Strait Islander people's material poverty is secondary to the more deep-seated deprivation that is the consequence of cultural invasion, removal from country, racism and oppression[6]. Research has shown that poverty is multi-dimensional and should not be employed as a singularised explanation of poor health in colonised communities. Defining poverty through Eurocentric material lenses tends to sideline the immense richness of relationships, connection to nature and Country, culture and spirituality[7]. Additionally, this measurement method does not consider the issue of overcrowding or extended family constructions that Aboriginal and Torres Strait Islander peoples often live in. Crowding is often a marker of poverty and social deprivation. It is estimated that approximately 10% of Aboriginal and Torres Strait Islander peoples live in overcrowded houses [8], with more adults living in one household "income" for the household may not fall below the level considered poverty. In many Aboriginal and Torres Strait Islander households, extended families are living together. This often means that a few adults and their incomes are providing for a large number of peoples. The current measurement of poverty is not taking any of these common scenarios into account.

To fully understand the extent of poverty in Aboriginal and Torres Strait Islander populations poverty must be described in a way that is in accord with the Aboriginal and Torres Strait Islander experience. The measures should be able to highlight the many inequalities between Aboriginal and non-Aboriginal Australians allowing for comprehensive actions to alleviate the devastating situation of so many Aboriginal people.

4. Colonisation and Intergenerational Trauma

Response to: (a) the rate and drivers of poverty in Australia, (b) the relationship between economic conditions and poverty,

The immense economic inequality we observe today is the outcome of European colonialism'[9]. Colonialism disrupted Aboriginal and Torres Strait Islander economic structures and replaced them with westernised institutions that disproportionately disadvantaged Indigenous populations[9]. With the colonisation, the disruption of society and policies allowing for financial abuse to be practised, such as the "Protection Acts" allowing whole wages, savings, entitlements, and other monies to be taken by the State, removed the opportunity of wealth-building for Aboriginal and Torres Strait Islander peoples leading to poverty being passed on through generations.

Intergenerational trauma is a result of colonisation and the historical and current events that followed, such as, forceful removal from land and communities, fragmented cultural identity, extinguishment of language, and experiences of racism. Aboriginal and Torres Strait Islander inequalities including the experience of both material, cultural and spiritual poverty is profoundly shaped by violence and continued institutional racism in the broader political system[7]. The unequal distribution of poverty should be understood because of policy decisions, that continue to shape who has access to power, resources, rights, and protections'[10]

Research shows that there is a direct link between colonisation, loss of culture, transgenerational trauma and poverty, homelessness, access to food, healthcare and education and a lifetime of increased vulnerability to disease[11]. The nature of these factors and the ongoing colonisation, intergenerational trauma, and racism has become cyclically ingrained in society. As a result, Aboriginal and Torres Strait Islander peoples will continue to be subjected to poverty in a chronic and invasive sense, across generations, without consistent and meaningful intervention.

The current approach to addressing various issues resultant from intergenerational trauma and associated poverty is through funding programs and initiatives addressing symptoms such as child protection, housing, food security programs etc. While important, these programs are only treating the symptoms of a deeper issue[12]. To address the profound issues associated with poverty in the Aboriginal and Torres Strait Islander population in Queensland the broader political system, must acknowledge, and promote healing and truth-telling to address underlying trauma. The ATSICCHO model of care which exist in Queensland provides holistic, comprehensive primary health care for individuals, families and the community that considers the underlying factors of ill health including of poverty and mental and physical holistic care.

5. Institutional Racism

Response to: (a) the rate and drivers of poverty in Australia, (b) the relationship between economic conditions and poverty,

Lack of access to public services is a consistent issue experienced by Aboriginal and Torres Strait Islander peoples residing in Queensland. Studies indicate that due to the actions undertaken by Australian governments since colonisation and the continued systemic and interpersonal discrimination and racism, mistrust in governments, workplaces, mainstream healthcare and a decrease in self-confidence and self-esteem amongst Aboriginal and Torres Strait Islanders peoples persists contributing both directly and indirectly to poverty. These issues are also evident in Queensland. Additionally, research has found that the "white sovereignty" and capitalism shape the racial distribution of resources and power, ultimately contributing to unequal distribution of poverty and health inequities[10].

Addressing all forms of racism in Government and other mainstream organisations, and rebuilding trust with Aboriginal and Torres Strait Islander peoples may improve confidence and access to education, employment, healthcare and other services resulting in increased economic stability.

The need to identify and eliminate institutional racism within Government organisations is recognised under priority reform three of the National Agreement on Closing the Gap, *Transforming Government Organisations[1]*. However, QAIHC is concerned about the progress toward implementation of this priority reform, noting that the Annual Data Report released by the Productivity Commission in July 2022 states that progress on priority reforms cannot yet be reported and that developing measures to report on progress is currently in early stages[13]. This is further reflected in the Closing the Gap Implementation Tracker, which does not provide any information on the progress toward achieving commitments under priority reform three of the National Agreement on Closing the Gap.

6. The consequences of poverty

Response to: (c) the impact of poverty on individuals in relation to employment, housing security, health outcomes and educational, (d) the impact of poverty amongst different demographics and communities.

6.1 Access to Services

Barriers to healthcare are also determined by geographic location. Regional and remote areas receive less funding per capita for healthcare than major cities[14] leading to a limited ability to provide comprehensive care for the community. People living in regional and remote communities in Queensland are often required to travel long distances to access specialist services. Services that are often associated with an out-of-pocket expense. Recent research from New South Wales has identified that transport to and cost of services continue to be amongst the main reason Aboriginal and Torres Strait Islander peoples did not accessing care[15] Due to the vast geographic distances in Queensland it can be expected that the same issues are experienced by Aboriginal and Torres Strait Islander peoples living in Queensland. In 2018 Queensland had the highest number of areas with "potentially poor access to primary health care services"[16] Many rural and remote communities in Queensland do not have ongoing and adequate transportation options to assist people from remote communities to more metropolitan areas to seek medical assistance and the transport available is often perceived as costly. While government subsidies are available to pay for travel and accommodation costs incurred by Aboriginal people when travelling to access healthcare, people may be required to pay up front costs, and not all associated costs may be covered[17]. In 2006 in was reported that amongst 1,187 discrete Aboriginal and Torres Strait Islander communities, 71% were at least 100 kilometres from the nearest hospital, 44% were at least 100 kilometres from the nearest ATSICCHO, and only around 10% of communities had an Aboriginal and Torres Strait Islander Primary Health Care Centre located within the community[18] Looking specifically at Queensland, access to services for Aboriginal and Torres Strait Islander communities in the Mid - and North West, Far North Queensland and the Torres Strait Islands are significantly reduced due to immense distances what peoples often have to encompasses to access both hospitals medical services.

The inability to pay for transportation to and for health services significantly affect Aboriginal and Torres Strait Islander people's health outcome.

People living in poverty are often reliant on bulk billing services to access health care. Together with the cultural safety and comprehensive care model provided by ATSICCHO, Aboriginal and Torres Strait Islander peoples living in poverty are dependent on ATSICCHOs for relevant care placing significant pressure on the service delivery.

Existing infrastructure is insufficient to meet the primary health care needs of many Aboriginal and Torres Strait Islander communities. This reflects the Health Sector Strengthening Plan, which states that

estimated infrastructure needs in the Aboriginal and Torres Strait Islander community controlled health sector is in the order of $1 billion [19]. Additionally, ATSICCHOs must consider the constant population growth and the future service delivery demand when determining infrastructure needs. This is particularly true in the remote areas of Queensland. Lack of consulting rooms, workforce and derelict infrastructure severely limits the sector's ability to function effectively, in an environment of increasing clients, episodes of care and client contacts [19, 20]. The financial situation of many ATSICCHOs in Queensland, particularly those existing in rural and remote areas, makes it difficult to respond to the complex needs of the communities they serve. With rapidly increasing population in all regions of Australia, including in Queensland, there is a significant need to increase health infrastructure in ATSICCHOs to meet increased demand [20]. Increasing ATSICCHO capacity through increasing available infrastructure, in the first instance, will have flow on implications regarding health service access, workforce, and access to specialist and ancillary services as part of the current comprehensive model of primary health care delivered by ATSICCHOs.

6.1.2. Access to services – Dental services

Aboriginal and Torres Strait Islander peoples experience poor oral health compared with the non-Indigenous population and are less likely to receive preventative dental care[21]. Differences in the determinants of health such as socioeconomic status, remoteness, access to services including distance to health services and available wealth, and cultural and environmental factors are all significant influences on the current patterns of oral health and disease[22-24]. Limited access to finance and transport is often cited in the literature as the main barrier to engaging in dental healthcare[22]. These factors have resulted in patterns of dental service use to address pain rather than preventable health practices[25].

Medicare offers rebates for both children and adults to access dental care in certain scenarios. To be eligible, children must be between two and 17 years old, be eligible for Medicare and they or a parent must receive an eligible Centrelink payment, such as the Family Tax Benefit A. The benefits are capped at $1,000 per child every two calendar years[26] which may not be efficient for someone with complex needs. Adults can also be covered if fulfilling certain eligibility criteria related to holding a concession card, however out-of-pocket costs are often still required[27]. The eligibility criteria for concession cards are stringent as they are often based on income[28]. As argued before this should not be the only indicator of poverty as this makes most employed people ineligible for a concession card and therefore

on able to access the public system for dental care. Most people including Aboriginal and Torres Strait Islander peoples are reliant on the private market for dental services leading to absence.

Private health insurance providers are often covering parts of dental care. Among people in non-remote areas, 20% of Indigenous adults had private health insurance in 2012–13, compared with 57% of all Australian adults. The most common reason that Indigenous Australians did not have private health insurance was that they could not afford it (72%)[27].

Poor dental health can in turn limit success in employment outcomes[29], and can create additional health complications in chronic health conditions such as diabetes[30] and kidney disease[31]. Diseases that are currently of high prevalence in the Aboriginal and Torres Strait Islander population.

In Queensland, only few Aboriginal and Torres Strait Islander community-controlled health services are providing dental care to the community due to lack of funding and difficulties in recruiting and retaining staff making local dental services difficult to sustain.

6.1.3 Access to services – Allied health

Allied health encompasses a broad group of health professionals. These are often used for the diagnosis, evaluation and treatment of acute and chronic diseases; promote disease prevention and wellness for optimum health and apply administration and management skills to support health care systems in a variety of settings. High cost of living and limited resources means that the delivery and uptake of allied health services in remote and very remote parts of Australia, including in Queensland are significantly limited, particularly for Aboriginal and Torres Strait Islander peoples[32]. Research from New South Wales has shown that two of the most impactful challenges to accessing allied health services for Aboriginal and Torres Strait Islander peoples are cost of services and the cost of transport to attend services[15]. Due to the factors mentioned in section 6.1. it can be assumed that the same barriers are existing in Queensland significantly limiting the access to allied health services for Aboriginal and Torres Strait Islander peoples residing in Queensland.

A Medicare rebate is available for a maximum of five (5) follow-up allied health services per patient each calendar year. For people with complex needs this is likely not sufficient as most peoples with moderate to severe health issues may need care from multiple Allied health professionals such as psychologists, dietitians, occupational therapists, and physio therapists for comprehensive care. Additionally, allied

health professionals often set their own fees resulting in a required out-of-pocket fee which for people living in poverty can be difficult to cover[33]. Referrals to allied health professionals through comprehensive care plans are predominantly made by GPs as part of the treatment of disease rather than as prevention of disease. Unless able to pay for services out of pocket preventative services are not accessible[33].

Private health insurance is often covering most allied health professions. However, as noted earlier in this submission, among people in non-remote areas, 20% of Aboriginal and Torres Strait Islander adults had private health insurance in 2012–13, compared with 57% of all Australian adults. The most common reason that Aboriginal and Torres Strait Islander Australians did not have private health insurance was that they could not afford it (72%)[27].

Limited access to allied health professionals and therefore a broad group of health professionals and treatment due to geography and poverty can lead to increased vulnerability to disease. Disease and disability are associated with limited employment opportunities[11].

6.2. Access to preventative health

Poverty is closely associated with deprivation of shelter, safe drinking water, nutritious food, sanitation, and access to health services. Factors that are associated with good health. At the same time, the diseases that are often a consequence of poverty often act as a barrier for economic growth leading to a recurring effect.

6.2.1. Access to preventative health - Access to healthy food.

Data from 2012-2013 found that 22 % of all Aboriginal and Torres Strait Islander peoples and 1 in 3 Aboriginal and Torres Strait Islander peoples living in remote areas were living in a household that had run out of food and was unable to buy more within the past 12 months compared with 3.7 % of non-Indigenous Australians[34]. Studies have shown that Aboriginal and Torres Strait Islander peoples across communities often perceive healthy foods as unaffordable, hence resorting to cheaper and often unhealthy alternatives[35]. Evidence suggests that people who experience poverty are more likely to maximise calories per dollar spent. Foods rich in fats, refined starches and sugars represent the lowest-cost options, with healthy options like lean meats, grains and fruits and vegetables more expensive[36]. In Queensland the issue of food security is particularly evident in remote locations such as Far North Queensland and the Torres Strait Islands and West Queensland where access to fresh food is often

limited and costly. However, poverty and therefore a level of food insecurity is widespread and evident across the Aboriginal and Torres Strait Islander population in Queensland.

The double burden of malnutrition is the coexistence of undernutrition and overweight, obesity, and diet-related non-communicable diseases across the life course within an individual or population. DBM can have severe consequences as it significantly increases the risk of physical and mental disability and mortality. The high prevalence of food insecurity often due to poverty, inadequate consumption of fruits and vegetables, and the high prevalence of overweight, obesity, and type 2 diabetes (T2D) in Aboriginal and Torres Strait Islander communities clearly shows the devastating consequences of the consequences of poverty to health in Aboriginal and Torres strait Islander populations.

As mentioned earlier in this submission health is closely related to child development, education and employment opportunities hence food security is a devastating and significant contributor to ongoing poverty of many families in remote aboriginal and Torres Strait islander communities[37].

6.2.1. Access to preventative health – housing and consequences of overcrowding.

Crowding is often a marker of poverty and social deprivation. Data shows that 14% of Aboriginal and Torres Strait Islander people in remote areas cited overcrowding at home as this type of stressor, compared to 9% of those living in non-remote areas[38] and 4 % of the entire Australian population[39]. There are large jurisdictional differences in the rates of crowding. In 2011, Queensland had the largest number of overcrowded Indigenous households (7,351)[40].

Overcrowded houses often lack facilities such as a fridge, cooking facilities, toilet, bath, and showers. Several studies have reported a direct association between crowding and adverse health outcomes. Overcrowding makes people more susceptible to disease, including infections, respiratory problems, gastroenteritis, skin diseases, significantly affecting physical health. Many of these diseases can be rapidly spread in overcrowded houses through sharing of beds and bed linen. Crowding also affects personal hygiene and dust control. Overcrowding can also present as an environmental stressor for people living in such households, including from issues such as a lack of privacy, which can have an impact on mental health. When people get sick from the consequences of over-crowding, are often required to leave their communities to seek treatment which can be costly and stressful for the family and broader community when already living in poverty. Additionally, treatment for conditions caused by overcrowding can have devastating consequences on an already tight household budget.

Concurrence between low SES and Rheumatic Heart Disease (RHD) has been well documented by several studies. Poverty, household overcrowding and distance from health care services are the main driver of RHD[41]. RHD has and continue to cause significant morbidity and premature mortality among Australian Aboriginal and Torres Strait Islander peoples living in poverty and often overcrowding. Primordial prevention strategies to reduce streptococcal infection are addressing household overcrowding and personal hygiene[42] which for people living in severe poverty can be difficult.

6.2.3. Access to preventative health – Mental Health

The mental health of individuals is shaped by the social, environmental, and economic conditions in which they are born, grow, work and age[43]. Poverty and deprivation are key determinants of children's social and behavioural development and adult mental health[44]. Poverty can be intrinsically alienating and distressing, and of particular concern are the direct and indirect effects of poverty on the development and maintenance of emotional, behavioural and psychiatric problems[45].

For many Aboriginal and Torres Strait Islander people, good mental health is indicated by feeling a sense of belonging, having strong cultural identity, maintaining positive interpersonal relationships, and feeling that life has purpose and value. The legacies of colonisation and the ongoing trauma experienced by Aboriginal and Torres Strait Islander peoples also affect mental health. Dispossession from land, forced removal of Aboriginal and Torres Strait Islander children from families, and institutionalised racism have enduring effects on social and emotional wellbeing[46].

In 2019 data estimated that 24 % of Indigenous Australians reported having a diagnosed mental health or behavioural condition. More than one in 10 individuals reported having diagnosed anxiety (16.5%) or depression (13.3%)[46].

Data has revealed that Aboriginal and Torres Strait Islander people with a mental health condition are more likely to experienced problems accessing health services (23%) compared to other groups[47]. The feeling of disparity in access was apparent across mainstream health services

Poverty and disadvantage can lead to mental health problems however mental health problems can also lead to impoverishment through loss of employment or underemployment, or fragmentation of social relationships and actions of crime. This indicates that both poverty and being an Aboriginal and Torres Strait Islander person are risk factors of developing mental health issues.

6.2.3. Poverty and imprisonment.

Aboriginal and Torres Strait Islander peoples are overrepresented in the Queensland and wider Australian prison system. According to the Australian Bureau of Statistics and Corrective Services, Aboriginal and/or Torres Strait Islander prisoners represent 26% of the total adult prisoner population in the Queensland prisons[48].

Data shows that approximately 2 in 3 (63 %) of the national prison population has not completed secondary schooling[49] and that about 1 in 3 (33%) of prison entrants said they were homeless in the four weeks before prison[50] indicating poverty. Additionally, data from 2021 indicates that 78% of the incarcerated population had experienced prior adult imprisonment[51].

This data indicated indicates that to reduce the prevalence of Aboriginal and Torres Strait Islander people within the prison population measures to improve the social economic status and rate of poverty amongst Aboriginal and Torres Strait Islander peoples must be considered to decrease the overrepresentation.

Prisons offer an opportunity to work with people through appropriate treatment and support aimed to help the offender become a law-abiding member of society. This might include developing skills to improve employability, treating mental health problems or provide financial planning support for the individual to break both the cycle of imprisonment but also poverty.

In 1991, The Royal Commission into Aboriginal Deaths in Custody recommended that corrective services, in conjunction with Aboriginal health services and other such bodies, should review and report on health service provision to Indigenous people in correctional institutions. It was also in this review recommended Aboriginal health services were involved in providing mental and physical health care for Indigenous people in custody[50].

7. Solutions

(f) mechanisms to address and reduce poverty;

7.1. Measurement of the extend of poverty

To fully understand the extend of poverty experienced by Aboriginal and Torres Strait Islander peoples the Australian Government must consider developing measurements that measure poverty beyond material poverty. Measures should take into consideration the differences in household and family dynamic skewing the current data as well as the difference in understanding of poverty by many Aboriginal and Torres Strait Islander peoples.

How poverty is measured makes a difference to poverty estimates (Saunders 2005; Walter 2007). Aboriginal and Torres Strait Islander households and communities are indisputably the poorest in Queensland and the wider Australia, regardless of whether poverty is measured in relative or absolute terms or whether income poverty or broader measures are used. However, to fully understand that scope of poverty in this population to allow for effective policies to be developed and implemented we must understand the full scope of the issue. To do so a matrix should be made in collaboration with Aboriginal and Torres Strait Islander peoples. This matrix should be able to highlight the many inequalities between Aboriginal and non-Aboriginal Australians allowing for comprehensive actions to alleviate the devastating situation of so many Aboriginal people.

7.2. Policy development acknowledging and addressing colonisation, intergenerational trauma and racism.

A social justice and human rights approach includes taking proactive steps to eliminate racism, addressing the social and cultural determinants of health, and responding equitably to meet the different needs between groups of people is needed through policy change to address poverty in Aboriginal and Torres Strait Islander communities [52],.

The Australian government must present clear policies with measures about what the government aims to do. When looking at the data it is evident that the current policies aiming to address inequities and inequalities including decreasing the prevalence of poverty in Aboriginal and Torres Strait Islander populations are not effective.

The Australian Government is not on track towards closing the gap by 2031. The largest barrier to engagement in education, employment and healthcare continue to be the presentation of racism and discrimination hence this must be acknowledged and addressed. New policies must be urgently made addressing continued colonisation, intergenerational trauma and racism as these factors are significantly contributing to the high prevalence poverty amongst Aboriginal and Torres Strait Islander peoples.

7.3. Policy development addressing the social determinants of health and collaboration with the Aboriginal and Torres Strait Islander peoples.

There is a need for the Australian government to reiterate their promise to Close the Gap. In 2021 the gap in life expectancy between Indigenous and non-Indigenous Australians was estimated to be 7.8 years [53]. The Australian government has set a target of 10 years, aiming to Close this Gap by 2031. To

address the inequality experienced by Aboriginal and Torres Strait Islander peoples, the health system must continue to adopt a social justice, and human rights approach to the health and care [54].

As it has been mentioned previously in this submission, the pervasive nature of ongoing colonisation, intergenerational trauma, racism, poverty, low education, unemployment, mental and physical complication has become cyclically ingrained in society. Therefore, without addressing the social determinants of health through policies which involve a multi-strategic approach focusing on changing the broader environment in which Aboriginal and Torres Strait Islander peoples live, Aboriginal and Torres Strait Islander peoples will continue to be subjected to poverty in a chronic and invasive sense, across generations, without consistent and meaningful intervention.

The Australian Government must acknowledge the unique needs of this population as well as acknowledge the continued effect of colonization and extensive racism.

Positive change towards achieving the aims of broader equity must be underpinned by shared leadership and decision-making with Aboriginal and Torres Strait Islander peoples. The priorities need to address historical and ongoing economic and social injustices and recognise Aboriginal and Torres Strait Islander people's sovereignty and innate rights to self-determination [53, 55, 56].

The Queensland Government has acknowledged that the core principle to achieve health equity for Aboriginal and Torres Strait Islander peoples is close collaboration and co-design. This includes engaging, consulting, collaborating, and empowering Aboriginal and Torres Strait Islander peoples to enable relevant decisions and meet the needs of communities. This same approach should be considered across states and territories as well as across sectors.

7.4. Aboriginal and Torres Strait Islander Community Controlled Health Organisations

ATSICCHOs deliver culturally safe comprehensive primary healthcare focusing on the environment in which the person lives. Their services include family and child protection and support services, social and emotional wellbeing (SEWB), alcohol and other drug programs, men's and women's groups, mental health care and general healthcare (as needed depending on the presentation). These services are considered more accessible to people in Aboriginal communities due to their culturally safe environment and free services for Aboriginal and Torres Strait Islander peoples.

ATSICCHOs play an integral role in the prevention and management of disease and ill health which includes addressing the social determinants of health effecting the community. Additionally, due to ATSICCHOs often being the most accessible healthcare provider for Aboriginal and Torres Strait Islander peoples they manage the diseases that living in poverty often promote. Due to the limited resources many ATSICCHOs are often unable to provide sufficient care for peoples experiencing complex needs.

Increasing funding directly to ATSICCHOs to increase their capacity to deliver more comprehensive care and prevent and respond to diseases associated with poverty. Further resourcing and prioritising ATSICCHOs as a key player in addressing the health consequences of poverty would support priority reform two of the National Agreement on Closing the Gap, *Building the community-controlled sector.*

Despite this recommendation in the 2021 final report and alignment with the National Agreement on Closing the Gap, the ATSICCHO sector has not yet seen an increase in funding for related programs[1].

8. Conclusion

In conclusion, QAIHC's submission highlights the complex and multifaceted nature of poverty in Aboriginal and Torres Strait Islander households, which is primarily a result of the ongoing impacts of colonisation and government policies. The submission emphasizes that poverty has significant negative effects on all aspects of health and should be understood as both a cause and an effect of social disadvantage, intergenerational trauma, and institutional racism. QAIHC calls for the development of measures to understand the true extent and nature of poverty in these communities and the acknowledgement and address of Intergenerational trauma, racism and ongoing colonisation and the dumb policies that perpetuate them. The submission further stresses the importance of addressing the consequences of poverty, such as limited access to healthcare, dental and allied health services, and preventative health measures such as food, housing, and mental health services. This can be done through funding of programs, more effective policies, and changing the current systems to be more appropriate for the Aboriginal and Torres Strait Islander culture. QAIHC calls for funding for ATSICCHO infrastructure, co-design and leadership from Aboriginal and Torres Strait Islander people to take care of the population as they know their own needs.

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QAIHC

Queensland Aboriginal and Islander Health Council

Queensland Aboriginal and Islander Health Council
ABN 97 111 116 762

BRISBANE
36 Russell Street, South Brisbane Q 4101
PO Box 3205, South Brisbane Q 4101
T 07 3328 8500

CAIRNS
6/516–518 Mulgrave Road, Earlville Q 4870
PO Box 12039, Westcourt Q 4870
T 07 4033 0570

qaihc.com.au